Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Dallas

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-14-2672-02

Carrier's Austin Representative
Box Number 44

MFDR Date Received
April 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by THR Presbyterian Hospital of Dallas to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine to be the correct amount for this inpatient surgery per the Texas fee schedule in effect as of 2008."

Amount in Dispute: $1,776.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our position remains the same that the maximum allowable has been reimbursed and the charge exceeds the fee schedule or maximum allowable."

Response Submitted by: Broadspire, 8827 W. Sam Houston Parkway N, Suite 110, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26 – October 7, 2013	Inpatient Hospital Surgical Services	$1,776.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 198 – Precertification/authorization exceeded
   - W12 – Reimbursement not recommended as service is not related to the injury
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - W1 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Were the services provided authorized?
3. Did the respondent raise a new issue?
4. Which reimbursement calculation applies to the services in dispute?
5. What is the maximum allowable reimbursement for the services in dispute?
6. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).
2. 28 Texas Administrative Code §134.600 (p) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;" Review of the submitted medical finds days submitted were from 09/26/13 to 10/07/13 for a total of eleven days. The carrier denied seven of the days as, 198 – "Precertification/authorization exceeded." The requestor provided no documentation to support that days from admission to discharge were authorized. Therefore on four of the eleven days submitted on the claim will be considered in this review.
3. The insurance carrier denied submitted codes 771 and 636 "W12 – Reimbursement not recommended as service is not related to the injury" during the medical bill review process. The dates of service referenced above contain unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical bill review process. Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute. Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, submitted codes 771 and 636 will not be considered in this review.
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).
5. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 470, and that the services were provided at Texas Health Presbyterian Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $13,824.71. This amount multiplied by 143% results in a MAR of $19,769.34.

6. The division concludes that the total allowable reimbursement for the services in dispute is $19,769.34. The respondent issued payment in the amount of $30,718.75. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 23, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.